A case for consolidating a human services department.

Cutting administrative costs of AFDC.

February 1977

THE SOCIAL AND REHABILITATION Record

Putting the cuffs on Medicaid fraud.
Page 8

FREE!

For all state and local agencies and volunteer organizations. Eye-catching, full-color posters to publicize the Early and Periodic Screening, Diagnosis and Treatment Program.

Good Health For Kids
The way to keep from having big health problems is to catch them while they're still small ones. If your children are
eligible for Medicaid
program that will fi
health problems, if
Good Health For Kids
The way to keep from having big health problems is to catch them while they're still small ones. If your children are
eligible for Medicaid, we've got a program that will find and treat their health problems, if they have any,
before they get too big. Why not check with your local welfare office and ask about the EPSDT program?

Place it in churches, self-service laundries, welfare offices, unemployment offices, day care centers, store fronts, low-income housing developments, supermarkets, food stamp distribution centers and other places parents are likely to see them.

Poster comes in two sizes. Wall poster is 20″ x 23″. Standup poster is 11″ x 14″. Blank space at the bottom of the poster is for the address and telephone number for local information.

The copy on the poster reads:

The way to keep from having big health problems is to catch them while they're still small ones. If your children are eligible for Medicaid, we've got a program that will find and treat their health problems, if they have any, before they get too big. Why not check with your local welfare office and ask about the EPSDT program?

THE SOCIAL AND REHABILITATION **Record**

For your supply, write:
Editor,
Room 5327 MES Building,
SRS/HEW
Washington, D.C. 20201

THE SOCIAL AND REHABILITATION
Record
Volume 4 Number 2 • February 1977

Articles

2 The Sixth Social Services System — by Alfred J. Kahn
An eight-nation study reveals its emergence and importance.

8 States Fight Medicaid Fraud — by James Bailey and Sandra Nix
A look at how States are attacking this public menace.

14 Cutting Administrative Cost of AFDC
Despite a budget freeze California AFDC and food stamp program thrive.

20 Moving Nursing Home Patients — by Martin Judge
Patients receive special preparation to avert the often fatal shock of relocation.

24 Consolidating Human Services — by Jim Parham
A case for centralizing human services based on Georgia's success.

Departments

13 Publications and Films

18 State and National News

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Joseph A. Califano, Jr., Secretary

Social and Rehabilitation Service

Don I. Wortman, Acting Administrator

Robert A. H. Wilson, Assistant Administrator for Public Affairs

EDITORIAL STAFF

Martin Judge, Editor

Patricia Fells, Assistant Editor — Wilma Chinn, Editorial Assistant

Drawing by Burkey Belser, page 24.

The Social and Rehabilitation Record is the official periodical of the Social and Rehabilitation Service of HEW. It is published 10 times a year by the SRS Office of Public Affairs. *The Record* is designed to provide information that will help professionals in State and local agencies and private organizations do a more effective job of carrying out programs which help people in need. The programs include social services for families and individuals, medical services, and assistance payments. Annual subscriptions are $6.40 (domestic) and $8 (foreign) and are paid to the Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402. Address manuscripts and article ideas to the Editor, Rm. 5327 MES Building, SRS/HEW, Washington, D.C. 20201. Telephone 202-245-2196. Publication funds were approved by the Office of Management and Budget on February 25, 1972, amended December 4, 1973.

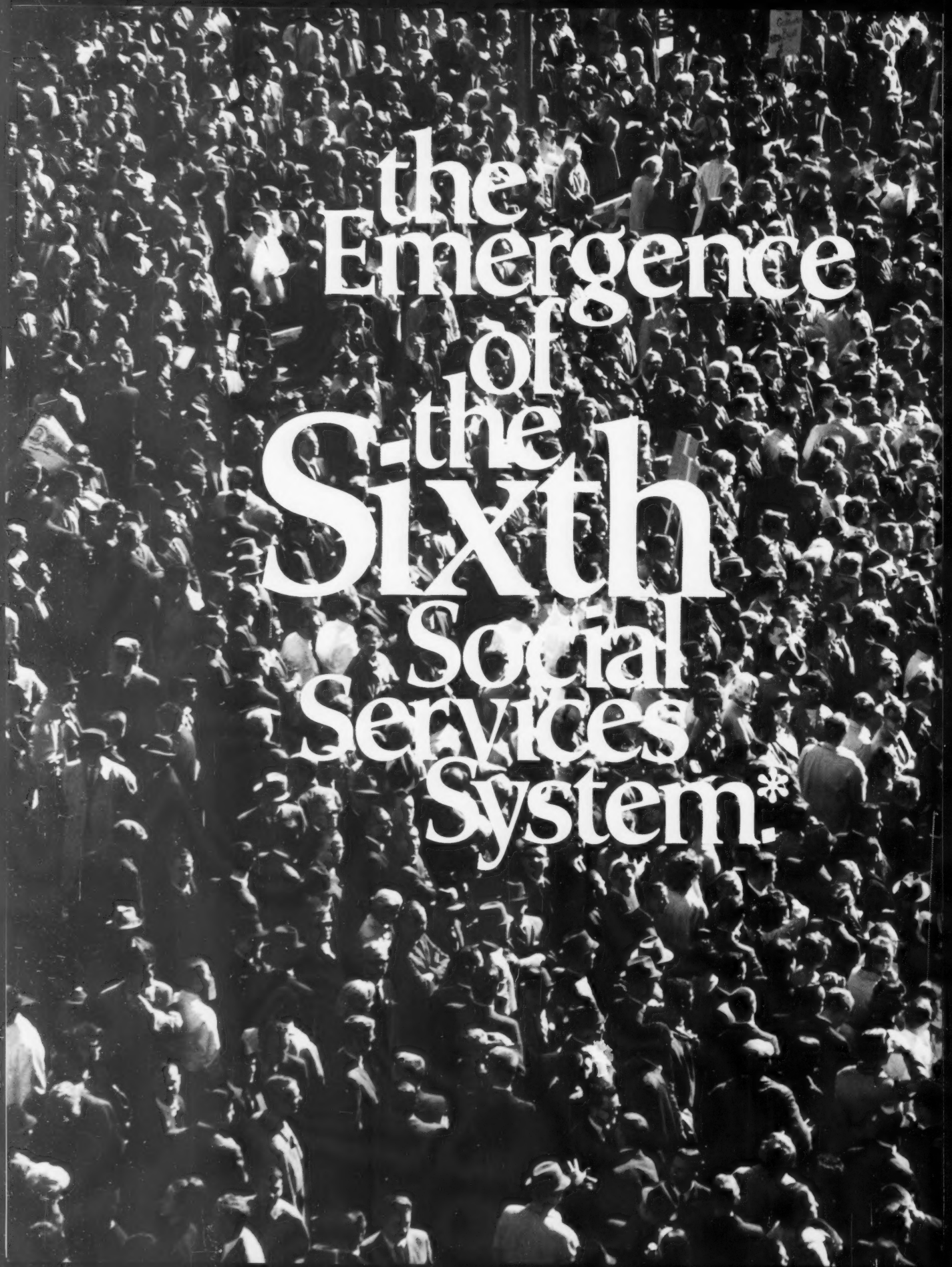
The opinions expressed in this magazine do not necessarily reflect the views and opinions of SRS or HEW.

When they ask...

. . . about a nursing home for a loved one, hand them this easy-to-read booklet. It tells how to shop for the home that will best fill the prospective resident's needs. This 33-page booklet includes a handy checklist to use when visiting nursing homes to evaluate them.

Nursing Home Care is available without cost in reasonable quantity from:

Social and Rehabilitation Service
Publications Distribution Office
Room G 115-B, MES Bldg.
Washington, D.C. 20201


the Emergence of the Sixth Social Services System*

A study of eight countries shows this new type of social service is growing in popularity even across political and cultural boundaries.

by Alfred J. Kahn

A sixth social services system is emerging. It has barely been noticed, but it has already become an important component of the standard of living in many countries.

For lack of a better name for it, I call it by its preferred British name, "the personal social services," or "the general social services."

The sixth social services system was studied in eight countries over a two-year period. The countries are the U.S., Canada, the United Kingdom, France, the Federal Republic of Germany, Poland, Yugoslavia, and Israel.

This study was undertaken because HEW faced program and policy questions about social services. For sometime standard questions about social services have been followed by quick answers — and we now know that the conventional answers clearly were wrong. Some examples:

- Will adequate cash preclude the need for socially delivered social services and "in-kind" benefits? The usual but incorrect answer was "yes."
- Will the evolution of a socialist economy and social system make general social services and social work unnecessary? The usual but incorrect answer was "yes."
- Are the general social services to be seen as residual, temporary and short-lived responses to breakdowns of primary institutions and therefore to be expected to disappear as soon as things return to normal? Again, the usual but incorrect answer was "yes."

All services and in-kind benefits cannot be cashed out. Personal social services are needed in all social classes and under diverse economic systems. They are not transitional things. The reality in the eight countries we studied intensively and in many others which we explored more generally is that the most developed industrial urban societies — those with the highest per capita personal consumption — invest heavily in general social services and do so in both good times and bad.

These services are permanent fixtures of the social infrastructure of modern Western States. Socialist countries, too, expand these services, and train and employ social workers as their economies grow and prosper.

These services also are valued and growing in less-developed parts of the world; but that is not unexpected. A basic core of general social services facilitates a more rapid developmental leap, while protecting citizens and assuring them rights — rights which were not available to the population at large in any country during the industrialization of Europe and North America.

While countries with industrialized, mixed economies structure their governments differently than do the East European socialists, there is no disagreement about which are the five basic social services systems.

Despite minor differences in names and some tendencies to subdivide or to combine, these five basic and familiar social services are readily identifiable as education, income transfers, health, housing, employment-training.

Though the sixth social services

---

* The sixth social services system is the system we have come to know as social services under Title XX of the Social Security Act. Dr. Kahn identifies the other five systems generally as education, income transfers, health, housing and employment training.

Alfred J. Kahn is a professor of social work at Columbia University. This article is based on the book he jointly authored with Sheila B. Kamerman, Social Services in International Perspective, *which will be published by HEW this spring. The report on each country has been published in a multivolume series. For details write Dr. Kahn at Columbia University, School of Social Work, McVickar, 622 West 113th Street, New York, NY 10025.*

General or personal social services...include specific concrete benefits as well as what some countries list as "social care services" . . . practical help which permits the elderly and the handicapped to continue to live in the community.

. . . these are no longer "poor laws" programs. They tend toward universalism, and are expected to be dignified, accessible, effective and good enough for all citizens.

system is new, its component programs are as old as human charity. Our country-by-country survey reveals remarkable similarity in program forms and content. The following is a partial listing of what were nearly always included in this service:

- Child welfare, including adoption, foster home care, children's institutions for the dependent and neglected, and protective programs for children.
- Family services and counseling.
- Community services for the aged.
- Protective services for the aged.
- Homemakers and home helpers.
- Community centers.
- Day care.
- Vacation camps for children, the handicapped, the elderly and average families.
- Information and referral programs.
- Congregate meals and meals-on-wheels.
- Self-help and mutual aid activities among handicapped and disadvantaged groups.
- Counseling programs for adolescents.
- Protected residential arrangements for youth.
- Specialized institutions for several categories of children and adults.

More important than program specifics, however, are functions these programs assume in the several societies and their roles in the total picture of family and community activity. These programs strive to contribute to daily living, to enable individuals, families and other primary groups to develop, to cope, to function, to contribute.

While the names of the programs and weighting of their functions differ across national boundaries, there is no difficulty in communicating concepts about these services.

The personal social services as we have observed them are addressed to one or more of the following tasks:

- Contributing to socialization and development — that is, offering daily living and growth supports for ordinary, average people (not just problem groups), a role shared with other non-market services but involving unique programs.
- Disseminating information about facilitating access to the services and entitlements in all six social services areas.
- Assuring for the aged, the handicapped, the retarded and the incapacitated a basic level of social care and aid necessary for them to function in the community or in substitute living arrangements.
- Arranging substitute institutional or residential care or creating new, permanent family relationships for children whose parents are not able to fulfill their roles.
- Providing help, counseling and guidance which will assist individuals and families facing problems, crises or pathology to re-establish functional capacity and overcome their difficulties.
- Supporting mutual aid, self-help and activities aimed at prevention, overcoming problems in community living, advocating changes in policies and programs, and service planning.
- Integrating the variety of programs or services as they impact the consumer to assure maximum benefit.
- Controlling or supervising deviant persons who may harm themselves or others, or those who may be harmed, while offering care, assistance, guidance, growth or change.

In general, the personal social services seem to have focused increasingly on developmental and socialization tasks, and on what is often called "prevention."

These remedial functions and treatment services of course remain urgent.

Findings and conclusions

Our first conclusion was that these six social services are clearly important. All the countries studied value them and assume their permanency and their growth. This is true of both

East and West.

There is an increasing recognition of: the need for community (non-medical) services for the aged; the responsibility to respond to the child care needs of working mothers; the community interest in the socialization of all children; the significance of such social cross-class problems as alcoholism, delinquency and drug abuse. With exceptions, these are no longer "poor law" programs. They tend toward universalism and are expected to be dignified, accessible, effective and good enough for all citizens.

Without doubt, income maintenance, health, education and housing are more important as service systems in all countries studied, but no one would forego personal social services and no one expects them to vanish. No one believes that an income strategy is an alternative for all services.

Nor do personal or general social services refer only to counseling, relationship help or substitute care. They include specific, concrete benefits as well as what some of the countries list as "social care services" — practical help which permits the elderly and the handicapped to continue living in the community.

The study of service delivery initially yields two major patterns: (a) the functionally unified and relatively (but not completely) comprehensive system with one local delivery outlet, as exemplified by the United Kingdom; and (b) the assignment of social work staff to many different institutions and their development of services in schools, health clinics, unions, industrial establishments, housing projects, social security offices, etc. The latter system, however, generates great pressure for service integration, program coordination, and for both administrative and physical structures.

While it cannot be said with certainty there is a possibility of convergence toward a free-standing personal social services delivery system, fully integrated in some countries. In others the service system seems categorically divided for children, the aged and "others."

Most countries are between these two options today but the experiments, innovations and investments appear to be in the direction of a free-standing system. The largest uncertainty and — we believe — the greatest danger would come from an attempt at integrated service delivery to complex urban communities of all or most of the six social services before the sixth develops its own organizational logic and identity.

The personal social services are a complex domain and require some structure and definition. Only a coherent system can be coordinated with other systems.

It is my view that social work as a profession could find its identity by alignment with a personal social services system. It is, after all, the lead profession in this area. Part of social work's current problem derives from an effort to be all things to all fields — and a failure to shoulder its responsibility and shape its roles in relation to the one system truly depending upon it. There are several other elements of convergence reflected by our study. There is convergence on the notion of a delivery system operated by local government.

The voluntary sector is, and will remain, an important if not the major factor in some countries. But there is convergence on the principle of a rather strictly enforced voluntary sector accountability. Its exact nature will vary with the country's tradition.

Then there is convergence on the idea of multiple-purpose social service outlets, some limited to the personal social services and some covering several systems. Experience suggests these outlets will be more effective if based in the neighborhood.

As decentralization takes place, more opportunity is offered for local community participation in service

Part of social work's current problem derives from an effort to be all things to all fields . . . and a failure to shoulder it's responsibility and shape it's role in relation to the one system truly depending upon it.

The personal social services are a complex domain and require some structure and definition before they mix with the better established and better understood systems.

planning and delivery. This is both cause and effect.

There is some evidence, if inconclusive, of convergence on the need for a "generalist" practitioner or team at the core of a local services system. The picture remains mixed but some countries do not see the possibility of a comprehensive and universal program unless there is, at the front line, a person or unit with substantial scope — one not too tied to a single intervention strategy or one type of response to need.

The United Kingdom offers the purest model of a team of generalists — yet it does not preclude intra-team expertise, special liaison assignments and experimentation with specialties. The French polyvalent worker is a generalist, too, but many people do not enter the system through her alone and all have the right to begin with a specialist.

The service unit remains a team in the U.K. and a practitioner in France. There are also mixes. Yet everywhere there is a straining for the generalist function, even in categorical systems. However, it is also recognized that these services cover a wide range: different age groups, health, average people needing developmental and preventive service as well as sick people and those needing protection.

There is, therefore, a parallel search for specialization, too. In some places it is within the generalist role and in others a second-tier operation. If there is specialization of the second sort, does it belong in a categorical service? On the latter points there is, as yet, little consensus. There are many variations. It is an issue for social work education, for the social work profession, as it is for public administrators.

The difference among countries is not in their service repertoires or their range of interventions. The commonalities rise above political and ideological differences. The variations reflect wealth and how long the system has had to mature. What is different among countries is the particular mix of elements in the generalist role, the conceptualization of specialty and its organizational base — and the work being done to resolve these critical questions of social service organization and professional development. ■

Data Collection Method

As the study evolved, it became clear that we were sampling program components and fields in a domain that was not fully organized and conceptualized. We began to explore functions, characteristics and problems of the sixth social services system.

The study was designed to focus on:

- The social context of social welfare.
- Child care.
- Child abuse and neglect.
- Children's institutions and alternative programs.
- Community care of the aged.
- Family planning.
- The local social service delivery system.

This provided a useful, many-angled view of services for average citizens and for those with problems, of community-based and residential care, of services to an entire demographic group and to a community constituency.

To avoid ambiguities deriving from language problems and to assure data comparability, stress was placed upon operational definitions and descriptive reporting. Examples of the type of questions which were asked are: How are children cared for while mothers work? Who pays? What are the explicit and implicit policies and the legislative base? What are the major service delivery models? Who administers? What is the eligibility? On what bases are programs evaluated and with what results? What changes are contemplated? etc.

Data were assembled in each country by research teams at the national level. Service models are described for various parts of the country. One or more local jurisdictions were selected in each country for more detailed description as well as analysis of the total system. Here the delivery system — if a system — is in focus.

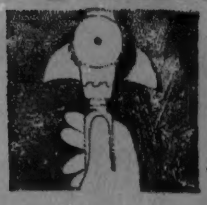
The major policy and program issues covered by the study were universalism-selectivity; degree and type of centralization-decentralization; relative roles and relationships of public, voluntary and government sectors; staffing patterns; service auspices; respective roles of consumers, volunteers, professionals, bureaucrats and political leadership; community care versus institutional care; boundaries and linkages in the social sector; new service interventions. Each of these areas was dealt with inductively, and thus not definitively, by assembling significant data, rather than studying it directly.

Coordination was achieved through three team meetings in Europe, visits to the countries by the director, extensive correspondence and exchange of materials. To test the conclusions before the final writing, we held conferences for the research directors of the countries in Washington, New York, Ottawa and Jerusalem.

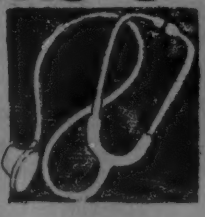
Questions may be raised about how countries were selected. Three of the countries were included because they were part of the U.S. P.L. 480 (counterpart funds) research program and a coordinated effort might enhance research results. All other countries were invited because they would encompass a range of governmental structures, differing roles for unions and industry, varied attitudes toward the voluntary sector, a variety of social services traditions, a wide variation in degree of community decentralization and alternative approaches to local service delivery.

The desire to understand options facing the personal social services in urbanized industrial countries and develop recommendations of immediate U.S. relevance kept us from including the less-developed world.

Children should be seen.



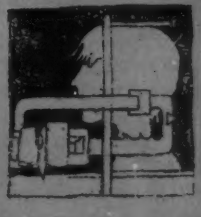
And heard.



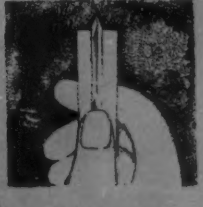
And ahhh'd.

And needled.

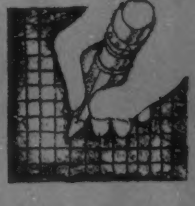
And measured.



And tested.



And charted.



And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.

States Fight Medicaid Fraud.

Techniques used by three States to curb Medicaid Fraud and Abuse.

by James Bailey and Sandra Nix

Recent investigations have uncovered evidence of ongoing operations to defraud the Medicaid program. Due in part to an early history of minimal control of the program, Medicaid defrauders have developed sophisticated techniques and the fraud problem is estimated at hundreds of millions of dollars. But recently the fight against fraud has shifted into higher gear and its impact is being felt.

Expanded efforts by HEW and the States to curb fraud and abuse resulted in 282 indictments and 137 convictions last year. In addition, more than $13 million has been recovered from those convicted. Even so, it is projected that the cases of fraud which have been uncovered reflect just a small percentage of what actually exists.

Currently, a number of States are trying to reverse this trend and their results impressively demonstrate that control of fraud and abuse is best achieved at the State level. Colorado, New York and Oklahoma are among those to implement successful approaches to curbing Medicaid fraud. Their techniques follow:

Colorado

In less than six months, an undercover task force of Colorado agencies exposed fraudulent and abusive practices by Medicaid providers on a large scale. Although final results are not in, the investigation has already produced eight indictments and one conviction. These are the first indictments ever obtained in Colorado for Medicaid fraud.

James Bailey is director of SRS' Office of Medicaid Fraud and Abuse Control. Sandra Nix is a program analyst in the same office.

To date, one nursing home operator has been indicted on 24 counts of forgery and four counts of theft for overbilling the State. Five other nursing homes have been similarly charged. Two pharmacies were indicted for involvement in fraudulent practices and a psychologist was recently convicted. Five other investigations are continuing based on leads received from the task force.

Cooperation is the keynote of this remarkably successful effort. In April 1976, the Colorado District Attorneys Association proposed a plan to help curb Medicaid fraud through a cooperative effort of the governor, State agencies and HEW. HEW allocated funds for six investigators making this the first such task force to receive HEW funding.

HEW's share of the joint task force budget was $79,261 for the six months of operation, and the State's expenses were projected to cost $71,315. The amount of fraud uncovered thus far has reached $100,550 and the total is expected to rise significantly as further indictments are returned.

Cooperative venture

To coordinate the use of all resources within the State, a high level committee representing various offices was appointed to supervise the task force. The committee was composed of high ranking representatives from the governor's cabinet, the Departments of Social Services, Regulatory Agencies and Health, the district attorneys office and HEW. The members met once a month to establish new targets, review activities and monitor expenditures. Because the committee members were the heads of the various agencies involved, decisions were immediate and effectiveness was assured.

Federal commitment

HEW funds for the task force were provided through the Intergovernmental Personnel Act Agreement. Thus, State and local government employees became short-term Federal employees.

HEW also provided guidance and information on fraud in the Medicaid program, such as the typical fraudulent schemes of each type of medical provider and the effective investigative techniques, as well as on Medicaid reimbursement rates and methods of cost reporting.

The approach

Task force members posed as prospective buyers of nursing homes in order to gain inside information about their operation. At one point, the front operation of the undercover team, Arnstein, Ltd., was approached by an out-of-State pharmaceutical company representative who expressed interest in a business relationship between the two.

After initial discussions, the representative requested exclusive rights to supply prescription drugs for the nursing home patients. The company then offered $50,000 worth of pharmaceutical cocaine as an act of good faith to seal the agreement. It was later delivered. As a result of the illegal proposition, further investigation was conducted and the company representative was indicted on charges of conspiracy.

To avoid any impropriety in investigation or prosecution, a chief deputy district attorney was assigned full time to provide legal advice. The support of the district attorney in each of the judicial districts eliminated any jurisdictional limitations or difficulties. Here, again, cooperation was the vital factor.

The investigative activity which was scheduled to terminate in December 1976 after six months of operation, has been extended because of the scope of the illegal activities uncovered and several investigations which are pending. Although HEW funding terminated as originally planned and the State is funding the additional effort.

The Colorado experience demonstrates the extent of fraud and the need for effective control of provider activities. Because of the unique cooperative atmosphere, and the coordination among local, State and Federal agencies, an unprecedented method of combating fraud has proven successful.

New York

With a staff of 300 attorneys, auditors and investigators, the State of New York has launched a major campaign to eliminate Medicaid fraud by private nursing homes.

Since January 1975, the new Office of the Special Prosecutor for Nursing Homes has produced evidence which has resulted in 76 indictments of white-collar crime. Of these, 22 persons have been convicted and the return of $3,892,445 in stolen Medicaid funds is assured.

The special State prosecutor in charge of the effort, Charles J. Hynes, estimates that $70 million in fraudulent nursing home costs were reimbursed over the past five years. False submission of direct costs, under-the-table kickbacks and phony construction costs are a few of the typical fraudulent practices which have been uncovered. A favorite scheme of nursing home operators is to write off personal expenditures as costs of doing business. Some examples of personal items paid for by Medicaid funds include works of art, vacations, mink coats and renovations of private homes.

Mandate to investigate

In late 1974, abuses in the nursing home industry caused an investigation into the scope of the problem. The result showed fraud and abuse had become ingrained in the system to a staggering degree and New York made a major commitment to combat it.

In January 1975, Mr. Hynes was named special prosecutor and given a mandate to conduct a thorough investigation to identify fraudulent practices and to prosecute those responsible for them. Before this there had been no serious investigation into this aspect of nursing home operations. In 1976, the budget for the operation was six million dollars.

Innovations in fraud control

A major innovation in New York's efforts to control Medicaid fraud is that the prosecutor's office is empowered to investigate both criminal and civil matters. These powers were delegated by the State attorney general. The ability to conduct both criminal and civil investigations allows the office to identify and recover Medicaid overpayments and refer violators for disciplinary action.

Although these powers are not traditionally prosecutorial, they assure continuity and long-term control throughout the investigations. Thus, the special prosecutor can use audit findings in all cases, while limiting the use of the grand jury to instances of clear evidence of criminal activity.

During its two years of operation, the prosecutor's office has developed a wealth of expertise and sophisticated investigative techniques. One such technique is the "team concept" which was developed to ensure the highest level of cooperation and coordination among the staff involved in a case. The team is composed of auditors, investigators and lawyers, and they are involved in all phases of the investigation.

During the investigation, the team seeks to establish if:

- There was a false submission of patient-related expenditures.
- The activity was intentional.
- There was a material misrepresentation of fact.

If the team is reasonably certain that criminal activity is involved, the evidence is presented to a grand jury.

Traditionally, a prosecutor's office operates without the full control, management or understanding of the cases since they are developed by other agencies. Under the new system all professional disciplines are involved from the inception of the investigation.

An investigative technique

Recently, 13 nursing home officials were indicted for willful violation of health laws and for conspiracy, and 11 suppliers of various goods and services to health care facilities were indicted for perjury.

The investigation began in May of 1975 when the prosecutor's office asked a nursing home operator to invite the 30 largest suppliers to his office to discuss a business proposal. All of the conversations were covertly recorded on a tape.

During the conversations, kickback schemes were explicitly discussed. In these proposals, the suppliers offered to bill the nursing home for an amount exceeding the purchase price or for deliveries never made. In turn, the nursing home operator could submit the bill to Medicaid and be reimbursed. An additional technique discussed was the offer of substantial loans from the suppliers in return for a long-term business contract. The loans would be repaid by means of inflated bills and subsequent Medicaid reimbursement. When confronted with the tape recordings, several suppliers agreed to cooperate with the investigation. The others were indicted after denying under oath that illegal propositions took place.

Those suppliers who chose to cooperate contacted other nursing home officials and taped conversations where kickbacks were again discussed. The average kickback offer amounted to $500 per month per supplier.

As a result of investigations such as this, it is suspected that as many as half of the 125 nursing homes in the New York area may be involved in kickback schemes. Evidence has been uncovered of kickbacks ranging from between five and 33 percent of the billing received by nursing home operators. It is estimated that suppliers bill nursing homes for about $250 million of goods and services each year.

Oklahoma

Less dramatic in its approach but certainly one of equal importance is Oklahoma's emphasis on prevention and tight management to control fraud.

One reason Oklahoma feels it has been able to manage its Medicaid program rather than reacting to problems only after they had established a strong foothold is that, in addition to being one of the first States to establish a Medicaid program in 1966, its experience in medical vendor payments predates Medicaid by eight years. Another is the continuity of the program due to having only one director since its inception.

The State reports that its success also lies in the organization of the program. All divisions of the Medicaid agency are located in one building, so coordination and exchange of information are greatly facilitated.

Provider relations

In order to establish good provider relations, minimal emphasis is placed on "police duties," according to Jack Stewart, director of the State's Special Medical Services Unit.

Mr. Stewart contends that good relations with providers and an education program for them are deterrents to fraud. The medical services unit provides a comprehensive manual for providers as well as consultation services on such topics as billing procedures. In addition, prompt payment for claims is a high priority.

The medical services unit performs all investigations. The agency neither has nor wants the typical investigative tools such as authority to obtain search warrants, confiscate evidence or make arrests.

Investigative efforts during 1976 resulted in one indictment and one conviction with the recovery amounting to $451,000. Oklahoma feels these statistics demonstrate that fraud does not exist on a massive scale because it is prevented.

Prevention and detection

The State has its own computer service, which allows the medical services unit to screen and verify all claims. The computer searches for providers with high utilization or payment levels, questionable or aberrant billing or current involvement in a fraud investigation. Such providers are placed on an "always audit" list. This system can detect payment for even subtle fraudulent billings which would not show up with a less intensive review. In addition to specific procedures known to be susceptible to fraud there are periodic unannounced reviews of providers.

Using these and other procedures, fraud is detected in most cases before a provider has the opportunity to develop sophisticated defrauding techniques.

Disposition of fraud cases

When an investigation is completed, if the facts support a charge of fraud, the case is referred to the unit's legal division. Since this division is conservative about referring cases to the district attorney, few cases are refused for prosecution.

Convictions of Medicaid fraud are intensively publicized. It is a widely held opinion in Oklahoma that the incidence of irregular billing drops following a successful prosecution. Thus, prosecutions are, due to the way in which they are handled, preventive measures.

Even if the evidence does not support a case of fraud, providers can be suspended from the program and negotiations made for restitution.

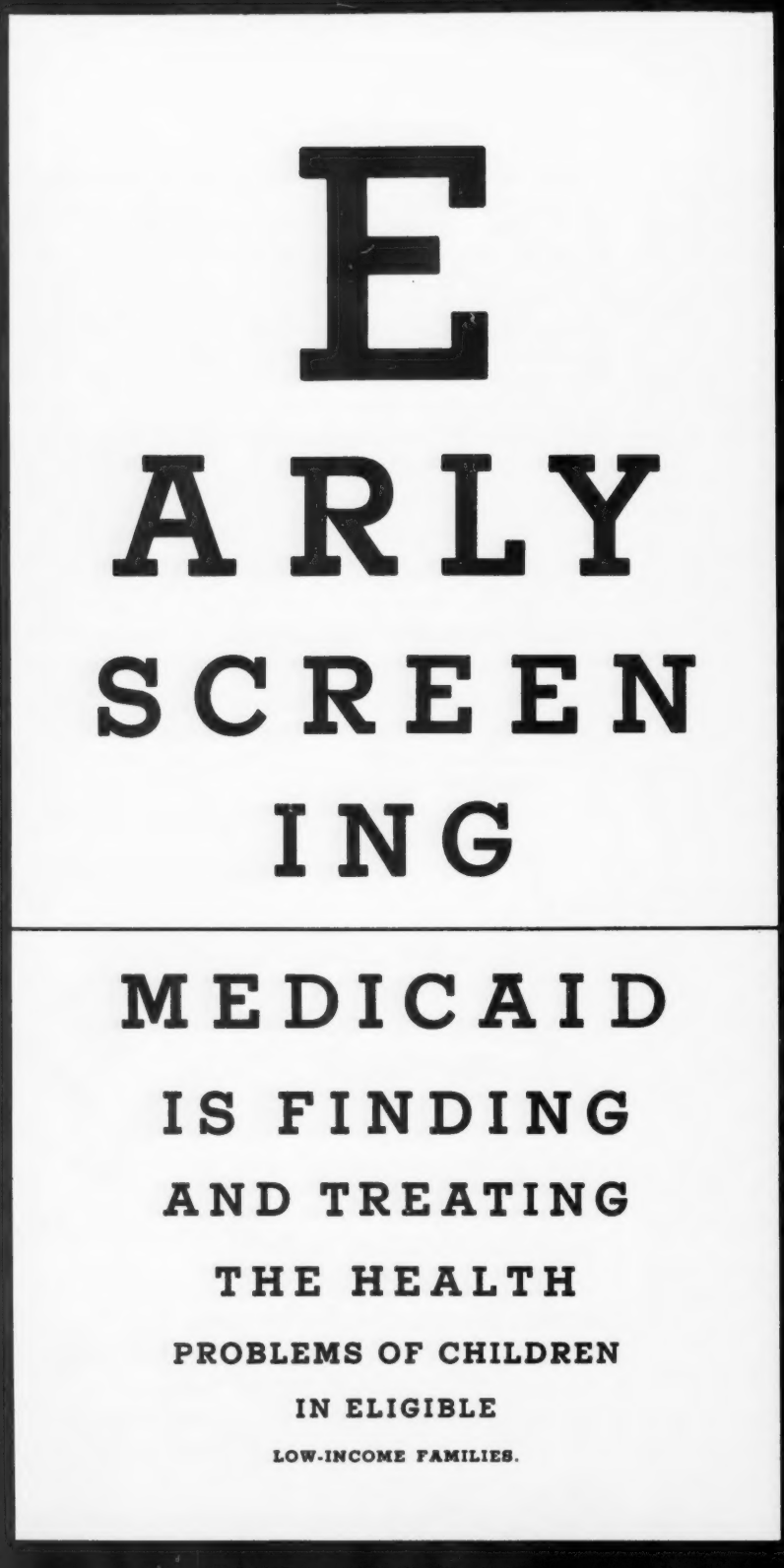
Regardless of the outcome of a case — successful or unsuccessful, prosecution, settlement or restitution — all the provider's future claims will be monitored.

WIN rules for the recipient

This brochure tells the AFDC recipient the essentials of the program and where to go for more information.
It answers such questions as who must sign up with the Work Incentive Program? When is an AFDC mother or caretaker exempt? What services and what training can WIN provide? What happens to the AFDC recipient who is required to sign up but fails to do so?

THE SOCIAL AND REHABILITATION **Record**

WIN and You is available without cost in bulk from the Social and Rehabilitation Service, Publications Distribution Office, Room G115-B, MES Building, SRS/HEW, Washington, D.C. 20201.



For a free supply of this poster write: Editor, The Social and Rehabilitation Record, Rm. 5327 SRS/HEW, Washington, D.C. 20201

Publications and Films

Please address all inquiries and requests to the addresses in the listings.

Publications

Evaluating Student Learning/Baccalaureate Programs and the Community College Transfer Student. Edward J. Mullen. Council on Social Work Education, 345 East 46th Street, New York 10017. $2.50

This book is based on a survey of administrators of social work baccalaureate programs about current practices and policies for integrating AA- and BSW-level training.

When Your Parents Grow Old. Jane Otten and Florence Shelley. Funk & Wagnalls, 666 Fifth Avenue, New York 10019. $9.95.

How can you deal with your parents' emotions and your own? How have others felt and what have they done when they've faced the same problems you're facing? Where can you find the supportive services you and your parents need?

This book provides information to help those with aging parents cope with the many problems facing them. It describes private and public resources and supportive services available. Chapters include Facing up; Finding Help in the Community; Improving the Quality of Your Parents Life; Diseases of the Elderly; Behavioral Changes; and Money Matters.

Prevent Child Abuse. National Committee for Prevention of Child Abuse. 111 East Wacker Drive, Suite 510, Chicago, Ill. 60601. Stock No. P-76-100. Single copies are free.

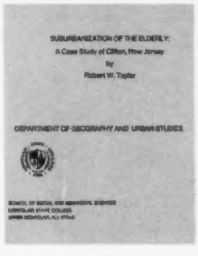
This brochure is written for those who want to know more about the problem, who need help or who want to give it. It gives an overview of some of the causes, symptoms, legal implications and procedures surrounding child abuse.

Also included are listings of national direct service organizations, government and private resources, and volunteer opportunities as well as a brief bibliography on general and specialized subject areas.

Sourcebook on Population 1970-1976 Compiled and edited by Tine Bussink, Jean van der Tak and Connie S. Zuga. Population Reference Bureau, Inc., P.O. Box 35012, Washington, D.C. 20013. $3.95.

This book contains listings of over 1,000 publications, graduate courses, population and family planning programs of government organizations and other sources of information in the field of population. Included are a glossary of demographic terms and an author index.

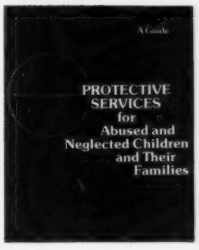
Suburbanization of the Elderly: A Case Study of Clifton, N.J. Robert W. Taylor. Dept. of Geography and Urban Studies, Montclair State College, Upper Montclair 07043.


SUBURBANIZATION OF THE ELDERLY:
A Case Study of Clifton, New Jersey
by
Robert W. Taylor
DEPARTMENT OF GEOGRAPHY AND URBAN STUDIES

This study has viewed the suburbanization of the elderly to see if suburban location has had a significant impact on their social needs and behavioral patterns.

It concludes that to an amazing degree, the elderly in the suburbs, particularly the lower-income elderly, bear a close resemblance to their urban counterparts. While the urban elderly tend to be more transient, generally lower in income, and more often in subsidized or public housing projects, they possess many of the same attitudes and needs of the suburban elderly: a need for social centers as a means of companionship; a means of transportation to reduce social isolation and increase sociability through visiting; a feeling that public programs and agencies are less reliable than families; and a negative image placed on public assistance.

Protective Services for Abused and Neglected Children and Their Families.



This guide is intended as a practical tool for State and local departments of public social services in program planning and administration. It consists of two major sections: protective services at the State level and protective services at the local level. At the end of each of these sections is a checklist which covers the major points in each.

The guide gives specific recommendations on protective services and the processes and mechanisms by which programs change.

Copies are available without cost from the Social and Rehabilitation Service, Publications Distribution Office, Room G115-B, MES Bldg., SRS/HEW, Washington, D.C. 20201.

Films

Time of Death. Color. 16 min. Focus International, Inc., 505 West End Avenue, New York 10024. Preview fee $35; purchase price $265.

This training film deals with the problems of health care providers confronted by patient death.

Statements by physicians, clergy, nurses, para-professionals and others combined with documentary photography help viewers confront their own death-related anxiety.

Included with the film is a free guide for discussion designed to help groups address such questions as: How does death-related anxiety influence relationships with patient, patient's family, other staff? How can health care professionals cope with their own feelings most effectively? How can health care professionals deal constructively with the special needs of dying patients and their families?

How a State Cut Administrative Costs of AFDC while Holding Down Error Rates.

"We were quite pleased to see the error rate go down. Overall we had a 26 percent reduction in dollars incorrectly spent."

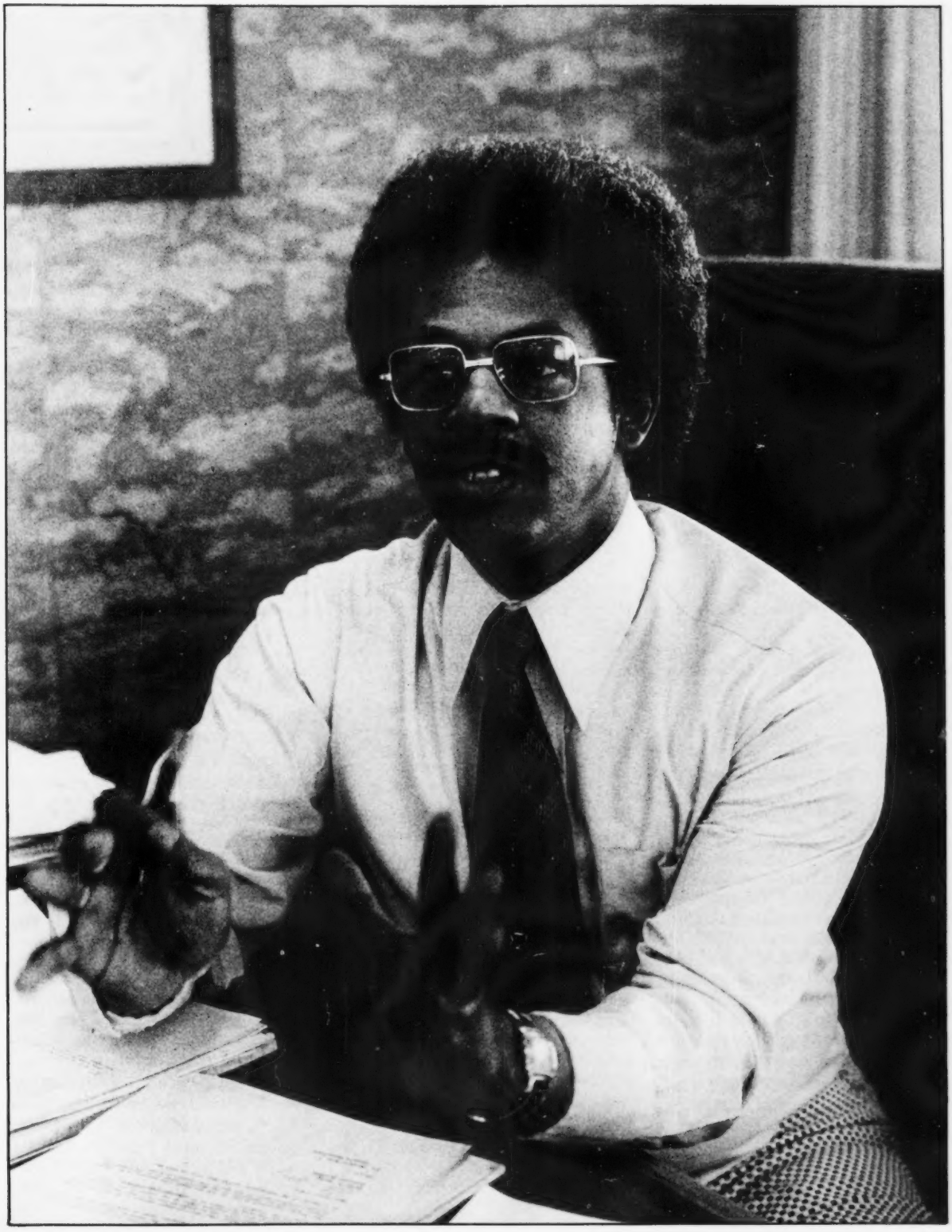
"The system was designed to improve over a three-year period. We expect to see more reductions in the next two years."

The California legislature curtailed the administrative budget of the Department of Benefit Payments for AFDC and food stamps for fiscal year 1975-76. To meet the cutback, the department slashed 10.5 percent from that budget. Surprisingly, the two programs not only survived the $31 million cut, they flourished. The Record *asked Marion J. Woods, who became director of the department in 1975, how this feat was managed.*

THE RECORD: Everyone is trying to control costs. How are you succeeding where many are failing?

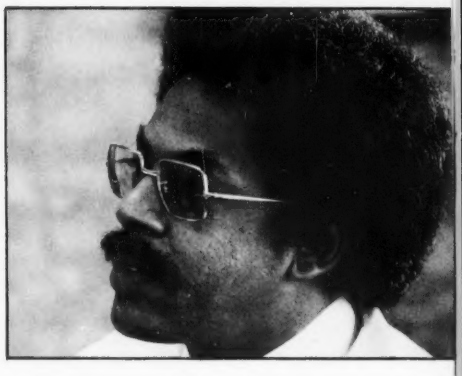
WOODS: There's really no single element of our system that hasn't been tried before to curtail management costs. We simply brought the right ones together for our situation.

Our problems were no different than those faced by other States. During the past few years, the administrative cost of running public assistance programs has increased faster than the caseload growth and cost-of-living salary increases. When our legislature put a ceiling on our administrative budget for 1975-76, we had the choice of simply passing on the bad news and letting 58 counties cope with the reduction as best they could — which probably meant cutting staff — or for the Department of Benefit Payments to perform an analysis of each county's costs and apportion the budget equitably among them, letting attrition take care of staff reductions.



"There's really no single element of our system that hasn't been tried before to curtail management costs. We simply brought the right ones together for our situation."

"We decided it would be best to go directly to the counties for participation in the decision-making process."



We decided to go the latter route. Our major areas of concern with the plan were the impact on union negotiations and the effect on error rates. Our error rates had been very good for a State of California's size.

A 10 percent decrease in projected administrative costs may not appear to be a severe cutback at first glance, but when you understand that the costs increased 29 percent from 1973-74 to 1974-75 and 17 percent from 1974-75 to 1975-76, the reduction was substantial. Of course, the figures do make us look a little better than they should. Some of these cost increases were justified by cost-of-living in-increases for county employees, caseload growth and the fact that the non-assistance food stamp program was not fully underway until 1974-75.

THE RECORD: What was the breakdown of savings for the various programs?

WOODS: The counties were able to save a total of about $31 million in administrative costs during 1975-76. The budget language covered five programs of which AFDC and non-assistance food stamps make up 95 percent of the administrative cost. The savings were $18.8 million in Aid to Families with Dependent Children and $12.1 million in the non-assistance food stamp program.

THE RECORD: Where did most savings occur?

WOODS: Basically in salaries, since salaries represent 85 percent of all welfare administrative costs. We required that salary budgets remain the same and, generally, that hiring be frozen. In Los Angeles County, by far our largest county, attrition customarily reduces staff by about 110 persons a month. However, we did not freeze raises because we realized that employees were being asked to increase their production.

Since the vast majority of the savings were accomplished through hiring freezes, this placed a greater caseload burden on eligibility workers. But the result was increased production and efficiency.

THE RECORD: What sort of problems did you encounter when you asked county employees to turn out more work?

WOODS: We decided it would be best to go directly to the counties for participation in the decision-making process. Although we had only 90 days to develop a plan, I felt it was absolutely essential to have substantial input in the planning stages. We met with members of the county welfare departments, including technical staff, the county welfare directors, the county supervisors associations and the county administrative officers. I think that the plan worked well because we openly laid out our objectives to everyone involved, learned the problems of those executing the programs and then drew up the plan.

Other State government agencies were also involved in planning. For instance, the legislative analyst's office, California's independent budget review section in the legislature and the department of finance in our executive branch.

Each county was apportioned a percentage of available funds based on its caseload requirements. But it wasn't a matter of our drawing up a laundry list, it was a matter of finding a fair and acceptable formula for allocating X number of dollars to cover Y number of expenses.

In order to help the counties stay within the limited amount of funds available, we developed a fiscal and statistical report that allows for county comparisons of the administrative costs of these programs.

THE RECORD: What guidelines were used in cutting costs?

WOODS: After some study we devised a formula based on workload, or the number of cases being carried by eligibility workers. Basically, the AFDC plan established averages for the number of cases carried by both intake and continuing eligibility workers. Averages were established for small, medium and large counties, with a tolerance of plus or minus five percent. Counties performing below average were required to increase their productivity so they could move half the distance from where they were in fiscal 1974-75 to the average for that year.

Those counties which were within or above the tolerance simply had

"We developed various tracking forms which show counties where they stand in certain areas . . ."

"Counties performing below average were required to increase their productivity so they could move half the distance from where they were in fiscal 1974-75 to the average for that year."

costs frozen. As a result of the freeze, some counties were required to work at the same level of productivity. In the non-assistance food stamp program the cost-control approach was similar to that of AFDC, which I just outlined.

THE RECORD: How did you control the costs?

WOODS: A bureau within the Department of Benefit Payments was created to monitor cost control activities and provide as much assistance to the counties as possible. We developed various tracking forms which show counties where they stand in certain problem areas, such as overstaffing. These forms are normally used on a monthly basis, but at least one county is using them daily.

Our department staff also keeps an eye on county expenditures and trends. We sound a red alert whenever potential problems crop up.

THE RECORD: How did the employees react to being asked to produce more at the same quality level?

WOODS: Since California's welfare programs are supervised by the State and administered by the counties, in some ways it was like too many cooks tending to the same kettle of fish. One of our major areas of concern was the effect on union negotiations. When we checked the union contracts, we discovered that some union caseload standards permitted heavier caseloads than called for by the cost-control plan.

THE RECORD: Why were the caseload standards of the unions higher than the standards under the cost-control plan?

WOODS: The union standards were reached by negotiation, with the caseload factor being just one part of the total contract package. The cost-control standards were arrived at in a much different manner. They were based on worker productivity, the county's size and the county's ongoing support expenses.

THE RECORD: Did your error rates increase as the caseload per worker increased?

WOODS: Our analysis indicated that the increased productivity we were asking for would not adversely affect error rates. This was a prime concern. We hoped to at least keep the error rate status quo. However, we were quite pleased to see it go down. Overall, we had a 26 percent reduction in dollars incorrectly spent.

THE RECORD: The error rates dropped, but what happened to the quality of services?

WOODS: We received very few reports of delays in processing applications and that sort of thing. In fact, the number of applications processed after our 45-day legislated limit showed a sharp decline statewide. We had anticipated problems in this area and so we built in a safety-valve feature where the cost-control formulas would be adjusted automatically to meet any increase in caseload.

THE RECORD: If you were able to cut 10.5 percent from your budget for 1975-76, why didn't you do it earlier?

WOODS: Previously, the legislature wanted us to concentrate on reforming the system, rather than on cost-cutting.

THE RECORD: Will you try cutting back another 10 or 20 percent?

WOODS: It might be possible. The system was designed to improve over a three-year period. We expect to see more reductions in the next two years.

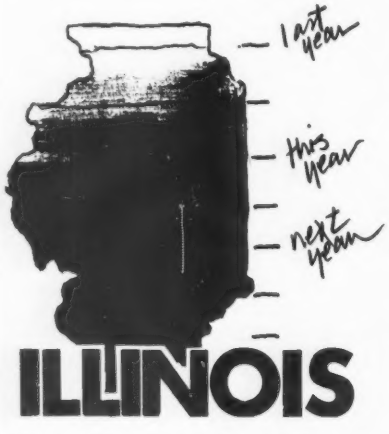
We are monitoring cost control very closely. In the future, the cost control plan will undergo refinements and we will continue to build improvements. Ultimately we hope to find the level at which client equity, administrative cost savings, and low error rates can be maximized.

Where do we go from here? I think our success may make our cost control plan a model for other States. My office is prepared to provide information and help others establish similar programs. We have various charts that show precisely where the money was saved. We will be pleased to share them with other States. ■

Overpayment may be kept if agency error.

A welfare recipient who receives an overpayment may keep it if it was due to an error by the agency.

A Federal judge in New Hampshire overturned a Federal regulation which permitted reclaiming the excess by reductions of future grants or appropriating other earned income. The judge ruled that the regulation violated the work incentive provisions of the Federal welfare law.



Ill. AFDC caseload drops for first time in 10 years.

More than 30,000 cases were removed from the AFDC caseload last year in Illinois. It was the first time in 10 years there had been a decrease in the caseload and it was the largest in 26 years, according to State Public Aid Director James L. Trainor. Mr. Trainor attributes the decline in part to changes in administrative procedures begun two years ago to keep ineligible persons off the rolls.

HEW statistics show that this decrease is five times greater than the national average, which is a decrease of one-half of one percent.

After reaching a peak of 806,707 recipients in February 1976, the number of persons eligible for AFDC dropped by more than 30,000 to 772-039 in November 1976.

Free newsletter

The *SRS Newsletter,* a monthly publication about the programs and people of the Social and Rehabilitation Service in Washington and in the States, is available without charge. Write: *SRS Newsletter,* HEW/SRS, Mary E. Switzer Building, 330 C Street, SW, Washington, D.C. 20201

Work-study earnings are excludable income.

Money earned under a college work-study program may, at State option, be totally excluded in determining the amount of AFDC payment.

This new SRS policy interpretation reverses a previous one which held that such earnings must be treated as income, thus reducing the amount of the AFDC payment.

A number of States and consumers have consistently objected to the agency's former position. They felt that since SRS allowed educational loans and grants to be excluded, it was inequitable not to do the same for work-study programs.

States have particularly objected with regard to adult students because treatment of work-study as income limits these students' capacity to meet educational expenses, which is the intent of the program.

Laws and regulations are silent on the treatment of income from work study programs.

Volunteer program for troubled youths, adults.

A score of volunteers are bringing a new dimension of help to troubled youths and adults in New Jersey.

Assignments for the volunteers include a big brother/big sister relationship with a child, social activities for those who are isolated or emotionally disturbed, tutoring and other types of one-to-one activities.

The Department of Human Services plans to ultimately use 60 to 100 volunteers to perform a variety of tasks to aid caseworkers. Volunteers undergo a three-session training course and are expected to devote five hours of their time per week.

The program is funded under Title XX of the Social Security Act and has an annual budget of $24,000.

Photo-IDs for nondrivers.

Elderly and handicapped persons in Ohio who do not have drivers' licenses and therefore have difficulty establishing their age and their identity for check cashing, will soon be able to purchase photo-identification cards from the State. The cards will be available to those over 65 and to handicapped persons over 18.

AFDC mothers challenge "cooperation" policy.

Five AFDC mothers in Massachusetts have filed a class action suit asking the Federal district court to halt enforcement of the so-called public welfare policy of cooperation to secure child support from absent parents.

The women claimed they have been dropped from the welfare rolls because they refused to cooperate with officials by naming the fathers of their children.

Stronger work incentive plan for Wisconsin AFDC.

To provide a stronger incentive for welfare recipients to get jobs, Wisconsin is considering a plan to assure that a welfare recipient can not receive more income than those who hold jobs. Under the plan, payments to welfare recipients would not be higher than the level at which taxes must be paid.

For example, a working family with four members now pays no income tax until its unearned income exceeds $451 a month. The proposal would limit grants to an AFDC family of four to that amount. Wisconsin's current payment to an AFDC family of four is $424 a month.

Alabama agency receives HEW training award.

The first HEW citation awarded a State agency for training was presented to the Alabama Department of Pensions and Security.

The plaque cited the agency for significant improvements in staff development through comprehensive training programs in general administration and management, supervision, financial aid and services, and child support enforcement.

The plaque was signed by SRS Regional Commissioner Virginia Smyth and HEW Regional Director Frank Groschell.

Placement odds double for hard-to-place kids.

In an effort to stimulate private adoption agencies to find homes for hard-to-place youngsters, Michigan has begun offering a placement fee based on actual costs of a placement rather than the previous flat fee of $500 per child.

The Department of Social Services projects this plan will save $60,000 in its first year. If private agencies fail to place a child within a certain period, the department assumes responsibility for finding the child a home.

The department anticipates private agencies will place some 250 children this fiscal year compared with 102 placements by private agencies last fiscal year.

Secretary's Briefing—Secretary Joseph Califano (center) visits SRS headquarters for a briefing on its programs by Acting Administrator Don Wortman (left) and other executives, including Ms. Bea Moore.

Letters to the Editor

How right you are.

To the Editor:

We in New Jersey couldn't agree more with the headline on Page 21 of your October 1976 issue: "Subsidized Adoption is Key to Problem Placements."

Our subsidized adoption program, administered by the Division of Youth and Family Services, a component of this Department, has enabled 559 New Jersey children to be placed in permanent homes since its inception in July 1973. Without adoption subsidies, most, if not all, of those children would have remained in foster care.

Subsidized adoption is one of the few government programs which actually save taxpayers' money while at the same time achieving a significant social aim. It does so because without the program, most of these children would continue to be wholly supported by the State until they reach adulthood.

Ann Klein
Commissioner
Department of Human Services
New Jersey

The Record invites notices of top-level appointments and news of State and local activities of interest to other professionals. Contact Patricia Fells, assistant editor.

Increased Sensitivity Lowers Death Rate in Nursing Home Moves.

Trauma for patients over 65 is greatly reduced by newly developed patient relocation team.

by Martin Judge, Editor

Statistics show that as many as 65 percent of elderly nursing home patients in the U.S. die within two months after being indiscriminately moved to a new nursing home. The cause of death is rooted in the trauma they feel at the loss of their old home—however bad—and the inability of the staff in the new home—however good—to help them adjust.

What the patients traditionally lost was paltry in dollars, but priceless in emotional attachment: a favorite chair; knowing the way to the bathroom, even though they could barely see; the security of sitting in the same place every day at mealtimes.

But now a new method of moving elderly patients reduces trauma to almost zero, so that the death rate is only 20 percent or slightly less than the percentage of deaths that would have occurred from natural causes. The new method was devised in 1974 by Pennsylvania's Department of Public Welfare when it learned that many nursing homes would be closed.

Due to the high volume of closings, the State contracted with the University of Michigan to help design the ideal system of relocating patients. The result was two techniques: one a training session for employees to increase their sensitivity to the special problems of the elderly, the other a technique for preparing patients for the move and assuring they are settled in their new home both physically and psychologically.

This service is available without charge to both non-profit and for-profit nursing homes. The relocation process may take from six weeks to six months, depending on the availability of beds in other nursing homes. Ideally, a team of relocation specialists will have six weeks from the initial contact with the nursing home staff until the patients are safely resettled, but sometimes a home will attempt to close in three or four weeks when faced with a court order.

Sensitivity training

"Our sensitivity training is designed to instill a high degree of empathy for the elderly in the nursing home staff," says Judy Maher, coordinator of the Nursing Home Relocation Team which operates in southeastern Pennsylvania. "Of course, the staff is aware the patients are having problems, but when they realize the problems stem from physical disabilities rather than personality quirks, moods or stubbornness, the tendency is to be more patient and more helpful."

Changes of attitude occur when the nursing home staff:

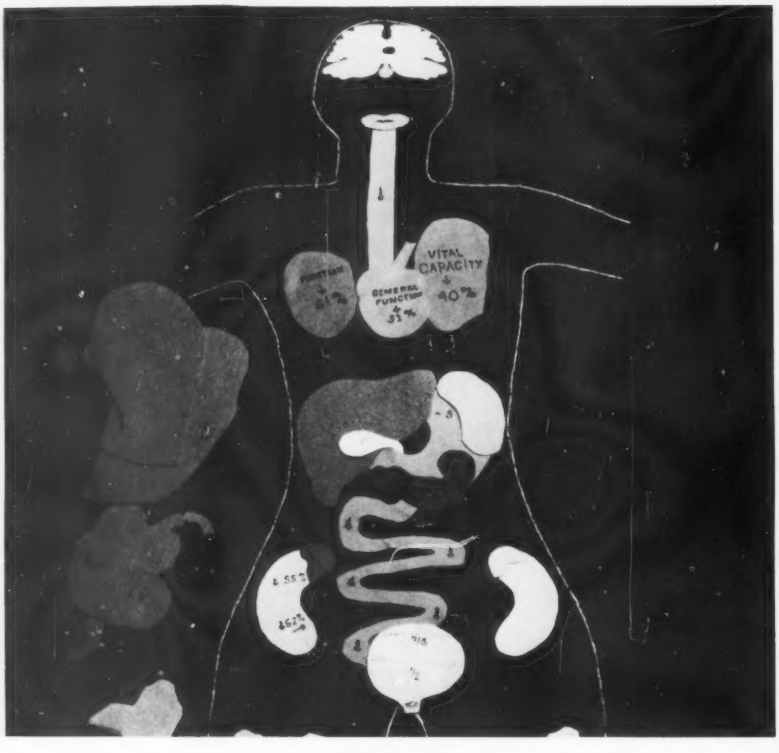
- Discovers they too cannot walk down stairs quickly when wearing fogged glasses. Said one nurse, "All I could see was the light at the bottom of the staircase—I couldn't make out the steps or the handrail—I was just groping along like I was 80."
- Finds it almost impossible to understand the simplest instructions with their ears plugged.
- Realizes how difficult it is to thread a needle or open a pill box when the sensitivity of their fingertips is reduced by spraying a plastic coating on them.
- Finds how tired they become when climbing stairs with cotton stuffed in their nostrils to simulate the shallow breathing of an elderly person.

In addition to the sensitivity training, staff members also receive a lecture on how various organs function with diminished capacity. (*See box.*)

Preparing the patient

The first step in readying the patient for the move is for the relocation team members to gain the confidence of the old nursing home staff. "When the staff is notified their home is closing, the immediate reaction is panic—get out and find another job as quickly as possible," says Ms. Maher. "It's a natural reaction, but our job is to convince them to stay with us until the patients are relocated. We do this by offering to help them find another job. Thus far, we've only had two or three who chose not to stay with us. Once the staff has agreed to cooperate, the next step is for our team to get acquainted with the patients on a one-to-one basis."

The team, which is composed of a registered nurse and two licensed



The 85-year-old body vs. the 30-year-old body

One of the most graphic demonstrations of the eight-hour course for nursing home staff is a lecture which compares the functions of an 85-year-old body with those of a 30-year-old one. "This subject really comes as a revelation, even to nursing home staff who have been around awhile," says Ellen Thomas, a registered nurse and member of the relocation team. Some examples of theories of diminished capacity according to Ms. Thomas follow:

- At 85 the capacity of the lungs is only 40 percent of that of a 30 year old and the oxygen exchange rate has dropped 61 percent. Staff members are asked to simulate the effects of the decreased supply of oxygen by dropping their shoulders forward and trying to take a deep breath. Not only does this diminished intake restrict activity, but a common cold becomes an extremely serious illness.
- Bones lose about one-third of their calcium when they reach 85. Stress causes still more calcium to migrate out of the bone. If the stress continues, the broken bone will not heal.
- The efficiency of the heart is reduced to 31 percent at age 85, and the efficiency of the kidney drops to less than half what it was at age 30.
- At age 30, one becomes aware his bladder is filling when it is half full. This awareness does not occur in the 85-year-old body until the bladder is ⅞ths full. Therefore, when an elderly person says he must go to the bathroom immediately, he is not being an alarmist. ■

practical nurses in addition to Ms. Maher, visits the nursing home, first to research patients' records and then to talk with them. The objective is to determine both their medical and social needs. Team members, wearing casual clothing rather than uniforms, strike up conversations with the patients to learn such things as if they have a favorite roommate, who they might like to move with, what type of recreational activities they prefer and if relocation would make it difficult for their family and friends to visit. "The major fear we encounter is that the patient's family will not be able to find him," says Ms. Maher. "We make a concerted effort to place a patient exactly where he will be the happiest and within 25 miles of his relatives —which is often closer than he was. We try to remain anonymous if possible when we begin talking with the patients because it is easier to establish a relationship when we are just friends rather than officials." If the home is closing rather than being moved to a new location, the relocation team, along with the patients' families, becomes one of the few links between their old home and the new one. In these cases the team will visit patients more intensively after they are settled.

Finding the new home

Convincing patients that moving to a new home is desirable is far less difficult than convincing a home to take a new patient. This is because the patients are usually on medical assistance, which necessitates a substantially greater amount of paperwork than a private patient. As an incentive for the home to take the patient, the team offers to complete all paperwork requirements, including medical, social, and financial updating of the patient's file, and to see that the State has processed all its paperwork.

The team also agrees to do an intensive followup for six months to

smooth out any problems that arise after relocation. This includes consultant services for the staff.

Settling into the new home

After the patient is told about the advantages of the new home, he is taken there for an inspection tour. Because patients associate an ambulance with dying, the team uses a blue and white van to transport them. The van accommodates wheelchairs and is fitted out with emergency equipment.

"We normally limit the number of patients visiting a home to four because they have so many questions that there needs to be a team member for each patient. For ladies the first question is usually 'Where is the beauty parlor and the chapel?' They then want to see how far the bathroom and dining room are from their rooms. After that we introduce them to their new aide and, ideally, show them the room that would be theirs.

"In most cases they are overjoyed with the new place. They frequently say, 'Let me just stay.' And in a few cases we have when the response was overwhelming. However, we find it is best to wait—a two- to three-day wait is optimum. If a patient moves the day after a successful visit, he does not have sufficient time to consider it and feel that he has participated in the decision. If it takes longer than three days to move, the prolonged period of excitement is too much. If a patient has a bad reaction to a home, which is rare, we find another home or take him back for another look."

During the period the team is preparing patients for the move, their relatives and friends are encouraged to increase visits. And when moving day arrives, they are asked to accompany patients to the new home.

"One of the phenomena we've noticed is that families get conscious struck and increase their visits until mother is relocated. Then they suddenly stop. This creates exactly the problem we have worked to avoid —separation of patients from their families because of the move. So we spend a lot of time on the telephone explaining to the relatives why we need them to also visit in the new home."

The critical period

According to observations by the four Pennsylvania teams and the University of Michigan, if death symptoms are going to appear, they will almost invariably occur within six weeks after the move. Because this period is so critical the team has devised a followup schedule which begins with firmly establishing the patient in his new home. "After making certain the patient's belongings are in place, we take a complete tour of the home, ideally with the aide assigned to the patient, answering all the patient's questions. We also pass along to the aide such information as whether the patient likes his coffee or tea in the morning, where he likes to sit in the dining room and other small personal preferences that can be extremely important to him." A complete nursing care plan is given to the charge nurse, with a complete medical history and suggestions of continued care.

A team member returns to the home to visit the patient within 24 hours after he is relocated. Then, sometime within the next 48 hours the patient receives another visit. The staff member returns sometime during the next week for a third visit and, thereafter, visits are scheduled for six months according to need. In December and January, a time of high mortality for the general population, visits are more intensive.

Thus far more than 1,000 patients have been relocated using this system. During the past few years, the relocation teams have shared information about their techniques with other States. Those wishing further information about the process may write *The Record.* ■

In a few words

This brochure outlines the new Child Support Enforcement program:
Who operates it.
Who is eligible.
How it works.
Where to apply.

THE SOCIAL AND REHABILITATION **Record**

Copies of *Child Support* are available without cost in bulk from the Social and Rehabilitation Service, Publications Distribution Office, Room G115-B, MES Building, SRS/HEW, Washington, D.C. 20201.

A Case for Consolidating a State Human Services Department.

By Jim Parham

The rationale for incorporating all Georgia's social programs and services into one large agency comes in four basic premises:

• A strong view that basic human needs are inextricably intertwined. A person doesn't have a separate physical sector, emotional sector, intellectual sector, vocational sector or economic sector. A person is a whole being, and you have to deal with him. One's economic status affects his emotional and physical status. Any serious health difficulty will have social implications. No single discipline or system can deal effectively with all these needs.

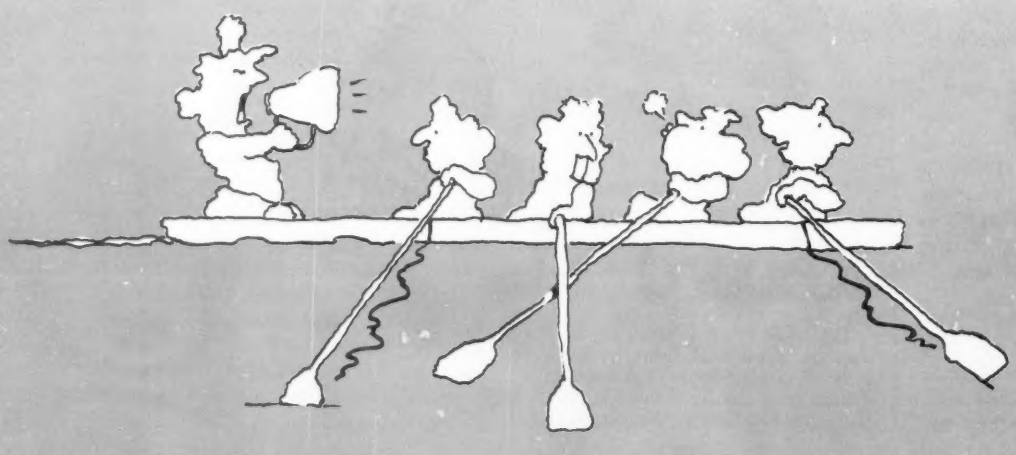
• A recognition that there must be a balanced development of human services. It is not sound, for example, to spend all your available funds for those who are mentally retarded and do nothing in maternal health, family planning and basic nutrition—all of which have some potential for reducing the incidence of mental retardation.

From another perspective, when we took over the mental health program in 1972, ninety-seven cents of every budgeted dollar went to support hospital programs and only three cents for community services. As a result, we had few services in the field with a potential for dealing with the mentally ill and perhaps preventing the necessity for expensive hospitalization. Neither was staff available to build bridges back to the community and help keep hospital stays to the minimum time necessary. Since 1972, we have shifted strongly to an emphasis on community care. The ratio of budgeted dollars for hospitals has shrunk to approximately 80-20. As a result, we have lowered hospital inpatient populations and reduced the average length of stay. We will save almost two million dollars on mental hospital operational costs this year.

• The fact that maximum cooperation and coordination is needed among the various services and disciplines. For example, if you want to build an effective program for alcoholics, you must have skilled physicians and nurses when you find someone in the acute stages of alcoholism. They must deal with the physiological reactions of the body or the alcoholic may well die. Once the patient is detoxified, however, skilled mental health professionals are required to discover why this person turned to alcohol as a crutch.

If you know about alcoholism, you realize that the syndrome usually involves parents, spouses and/or children. So the treatment team must have a social service component to

Jim Parham, former commissioner of Georgia's Department of Human Resources, is a member of the White House staff in the Office of Intergovernmental Relations and Secretary to the Cabinet.



give attention to the family setting. The best clinical work will be negated if the patient returns home to the same stresses and attitudes that played at least some part in the development of the illness. Alcoholism often results in the destruction of original career lines so there is a need for vocational rehabilitation. Frequently families are made destitute by alcoholism and public assistance is required. In short, you can't deal with serious cases of alcoholism with a single-discipline approach. To build an effective program, the work of several disciplines and systems must be coordinated; and this is more likely to work under a consolidated administration.

• A recognition that the vast amounts of money now being expended on human services demand attention to economies of scale. Reorganization does not guarantee economies of scale, but again they are more likely under a consolidated administration—if for no other reason than that the top managers have a stake in them. It is possible to provide services such as accounting, staff planning, budgeting, staff development and public information for a lower unit cost in a large department.

An example of an economy of scale was when we combined the food services and infirmary operations of two large institutions and one small one which were in a stone's throw of each other, resulting in a savings of well over $100,000 per year. It's possible to aggressively encourage collocation of units—sometimes saving rental costs and almost always improving access for clients. We have collocated units in over 100 places.

Equipment can also be shared. In one instance we found that expensive buses were being used to transport mentally retarded persons to a day care program. The buses sat there all day unused while a senior citizen's meals program was without transportation. After some negotiations over Federal categorical restrictions, we managed to use the buses during the noon hour for the meals program.

The restructured agency

When and if such premises are accepted and a new agency configuration is created, the challenge becomes the response to fundamental issues. The first is:

Will the department's aim be to coordinate existing programs more effectively and fill in gaps in current services; or will a radical restructuring of existing agencies be attempted to reduce duplication, more clearly define program boundaries, and rapidly move toward complete services integration?

Either approach can represent progress, but the answer has extraordinary consequences. Regardless of one's belief in the correctness of one approach or another, the question should be carefully considered in light of political and professional power balances.

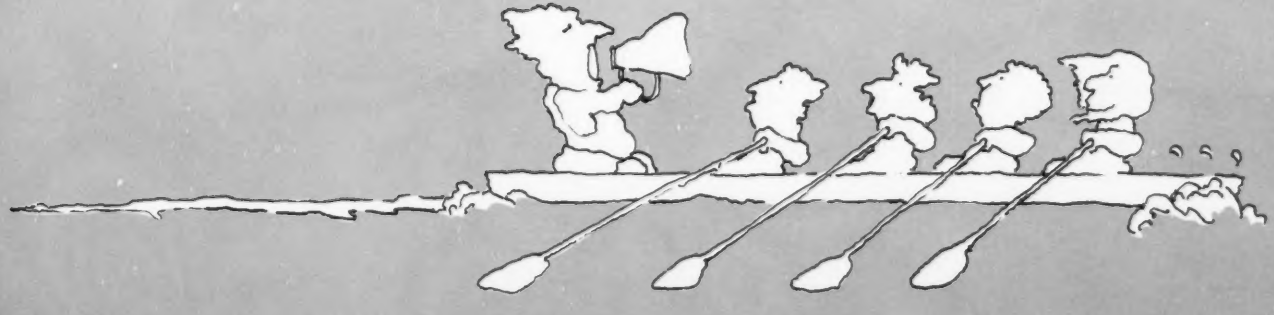
A second important issue for the consolidated agency is:

How can populations at risk be accurately identified and ranked in priority for resource allocation? Who will rank them—the governor, the legislature, the department, the divisions?

For example, should we provide first for children who need expensive, intensive residential care or should we build a community out-patient system? Should we make an investment in good maternal health programs for high-risk expectant mothers or more service for the congenitally handicapped who are already born? (Florida has a Federal capacity-building grant for a program called Scientific Needs Assessment Program which involves the collated use of existing socio-economic data, results of interviews with randomly-selected potential clients, and questionnaires filled out by key professional informants. We will follow this closely and, in the meantime, are working on our own list of social indicators.)

Third, and probably eventually the biggest question of all:

How can service interventions be objectively evaluated? Most of our efforts in this realm are primitive in the extreme. Usually we bog down in just trying to define reasonably measurable objectives. We seldom even get to the acid test which is not only, "Do some clients benefit in measurable ways?" but also, "Does intervention render a greater benefit when compared with the behavior of similar persons who do not



receive the service?"

If we ever get into evaluation in a serious way, and we must for both intellectual and fiscal reasons, it is my opinion that we are going to shake to the core some of our most cherished sacred cows.

Other questions include: Shall administrative support services be centralized or decentralized? The answer affects the power and discretion available to the Department head. Shall we purchase services or build our own staff? The implications are highly significant. Single entry intake? Common I & R? Collocation? Shared staff? Shared equipment? Merged functions?

These and scores of other questions abound. They are made more difficult because few of us have a clear vision of what we want the human service system of the future to look like. One reason for that is that we are not sure enough of the efficacy of existing service delivery modalities. Another reason is that in our evolving post-industrial society, the forms of visible human distress keep changing. New social circumstances and new knowledge will keep spawning new modalities of service, and that is as it should be. In fact, what we probably need is a sunset law for obsolete models.

Cooperation among States

It was due to the complexity of these questions that the Southeast Institute for Human Resources Development began in March 1974 with an informal alliance of four States in the region—Florida, Georgia, North Carolina and Kentucky—all of which have consolidated human services agencies. Two years ago, with assistance from HEW's Region IV Office, the institute was incorporated and a full-time executive director was hired.

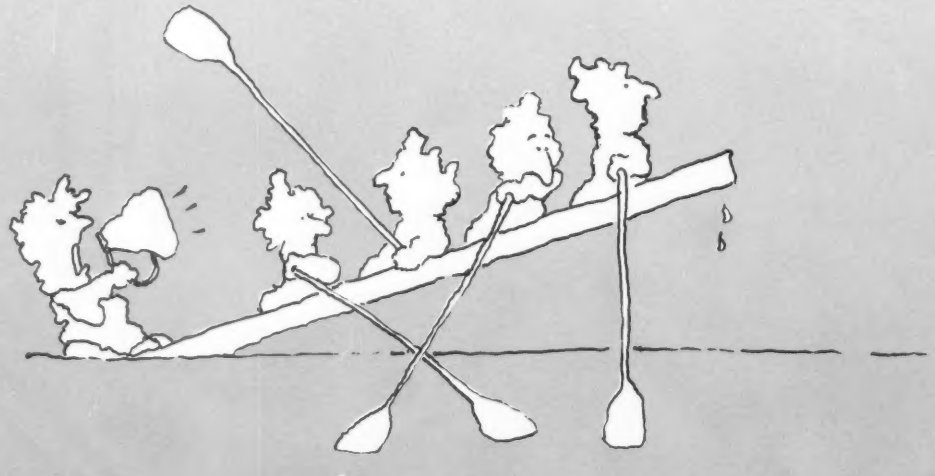
From its inception, the institute has welcomed and has had participation from other States in our Region. In addition, Virginia and Louisiana have asked to become full-fledged members.

Even though the States in the Southeast generally show common geographic, socio-economic and political characteristics, their individual environments have produced remarkably distinct and unique organizations for human services. While four of the States are umbrella States, no two of them are exactly alike. Yet, each finds a deep commonality in the issues and problems faced in the daily management of their services.

We believe many benefits have accrued through this regional relationship. Our quarterly meetings and workshops bring Federal and State human resource officials together to address common problems and issues. The meetings have provided good leverage as a mechanism for integrating the concerns of the States into the decision-making process of HEW and other agencies. In addition, we have used this forum as an opportunity to work toward uniform interpretations of regulations, pursue more timely release of regulations, and make key Federal personnel more accessible to the States.

The institute, on a State to State basis, has provided the opportunity to better use the special knowledge and skills of each individual State to compare, plan, program and evaluate. Using the institute as a central clearinghouse, the States have shared information and technology on methods and experience in a variety of human resource programs. North Carolina, for example, has shared the extensive work it completed on a management-by-objectives program. Our Georgia Department provided materials and other technical assistance to several States on our Random Moment Sampling Program designed to more clearly identify and allocate costs. This has been especially helpful to us in securing Federal financial participation on administrative costs. We feel that these and many more opportunities have helped to improve general administration and human services delivery in the region.

In addition to planning, developing and carrying out the details of our regular meetings, central institute staff work has been done on a variety of topics. Surveys on basic management activity and special research projects in administration have been carried out. The staff has also established and maintained liaison with



State, Federal and other parties interested in human resources administration. As an example, we recently cosponsored a national workshop on coping with the demands for change in human resource administration with the American Society for Public Administration.

We are also now involved in or proposing to undertake several special projects related to human resources administration:

Program Evaluation and Management. At our most recent institute meeting in Florida we sponsored a workshop on evaluation programs and problems. As a result of these discussions, we are planning a one-day session for directors and key staff on evaluation management. The program is being developed for us by the Federal Executive Institute in Fredricksburg, Virginia. That institute will provide the actual training and resources.

Regional Planning Study. In cooperation with the HEW Regional Office, we are conducting a "State of the Art" Study of Human Resources Planning in the Southeastern States. A detailed comparative analysis of the planning process in each State will be produced.

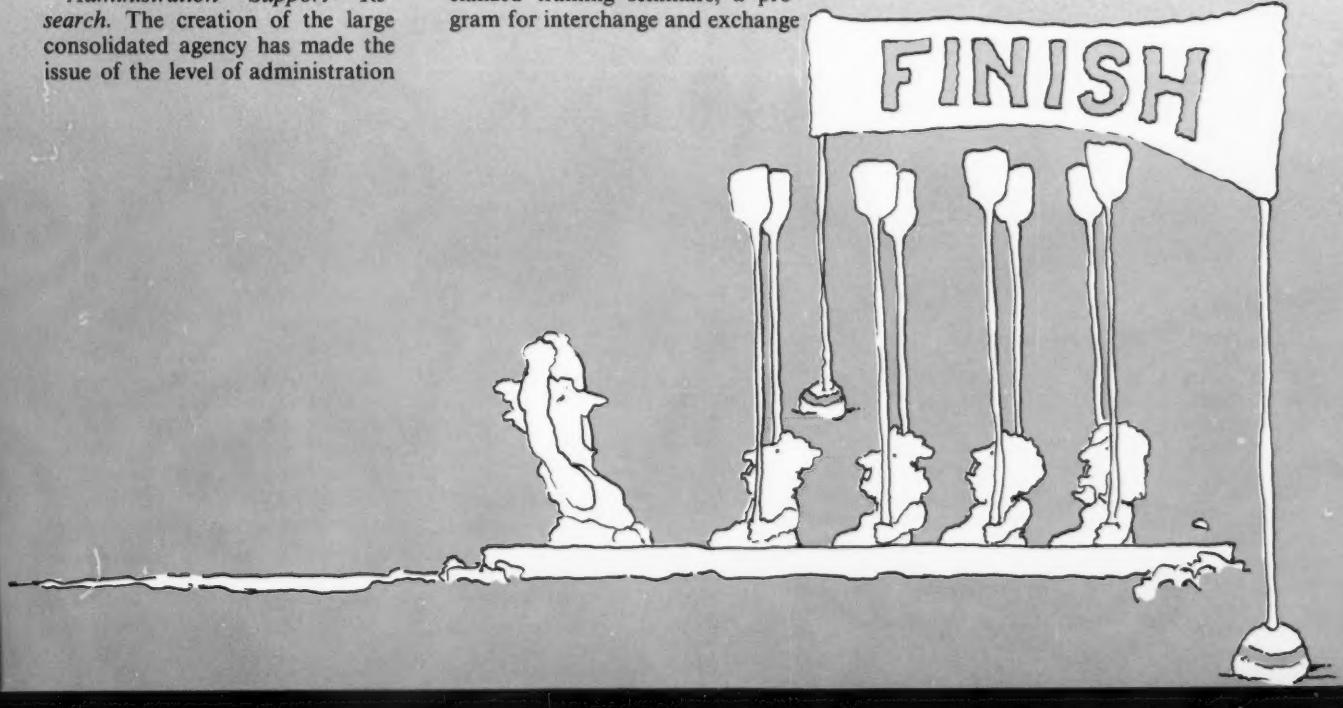
Administration Support Research. The creation of the large consolidated agency has made the issue of the level of administration necessary for the support of these departments highly visible. Questions concerning what is an adequate and reasonable level of administrative support for human service activities have become more pressing and persistent, particularly from State legislatures. Our effort last year in this area yielded a descriptive study of the nature and level of administrative support of the front line service workers in benefits and social service programs. A follow-up study currently underway will attempt to identify variables that account for the differences between the States. It will also try to determine if program output is clearly enhanced by a greater quantity of administrative support personnel.

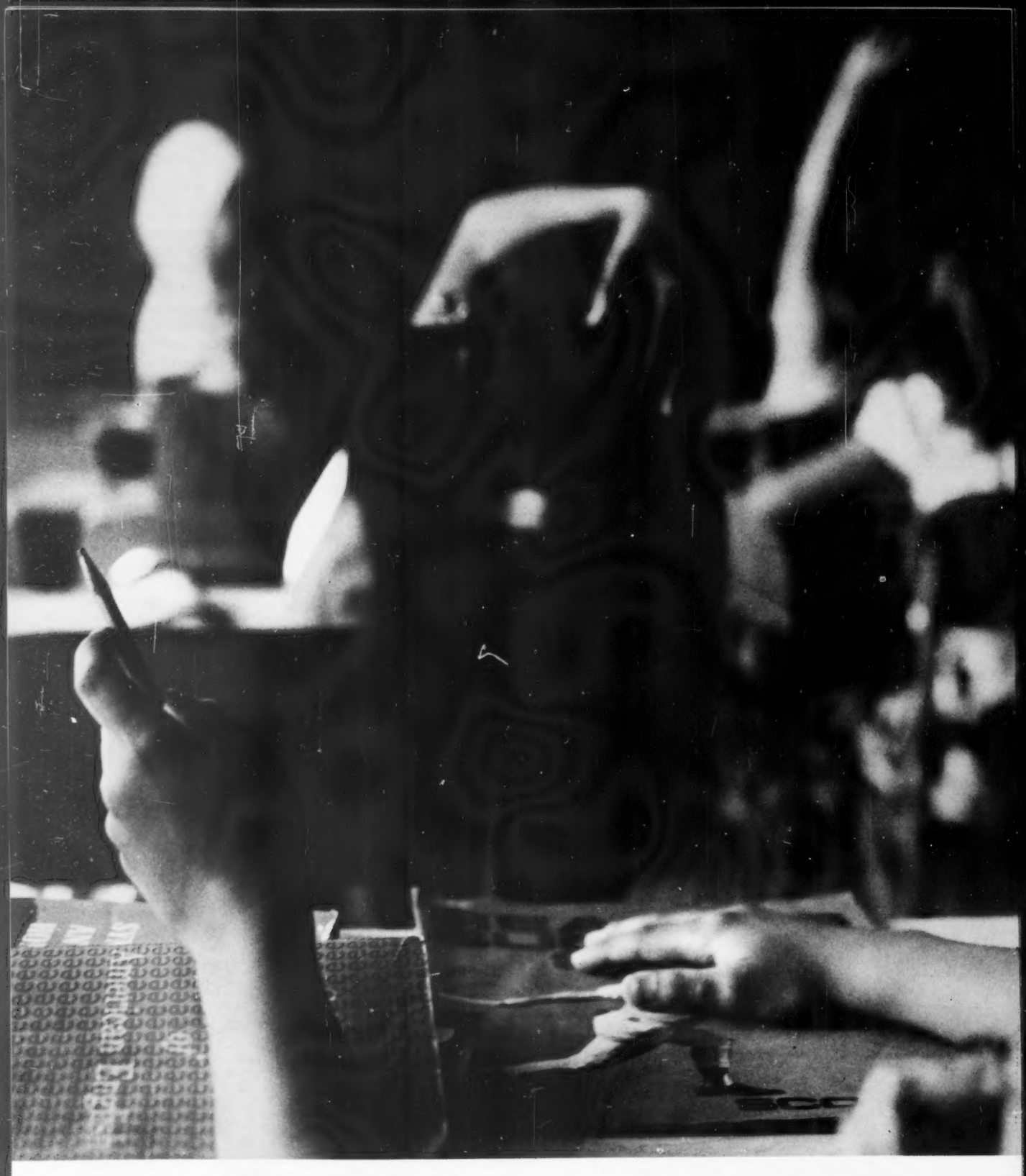
Human Resource Management Skills. State agency administrators have increasingly expressed concern in regard to their needs for improved skill in the management of human services at all levels of their agencies. We have on our agenda over the next few months a project to conduct a survey of management and technical skills needed by our member agencies. This project will also suggest alternative ways for meeting these needs. Some possibilities are specialized training seminars, a program for interchange and exchange of personnel, and perhaps a regional management training institute in cooperation with one of the universities in our region.

Management Information Systems. Many of the Southeastern States are concerned about the tremendous investments being made in developing MIS as well as the relationship of these systems to the management of programs once implemented. We hope to undertake a project soon to answer two critical questions: (1) what are the specific pieces of information that top managers need to oversee and understand the status of programs; and (2) once identified, how can the information be secured on a timely basis and distilled into a useful format?

During the course of this next year, there will be other problem areas identified for which we will probably undertake basic activity.

In summary, I believe that the institute is an exciting, new form of regional cooperation that offers the states a great opportunity to maximize their efforts in human resources development. This past year's efforts were only a beginning. We hope to do an even better job collectively at making our human resource goals a reality.





Seeing is believing.

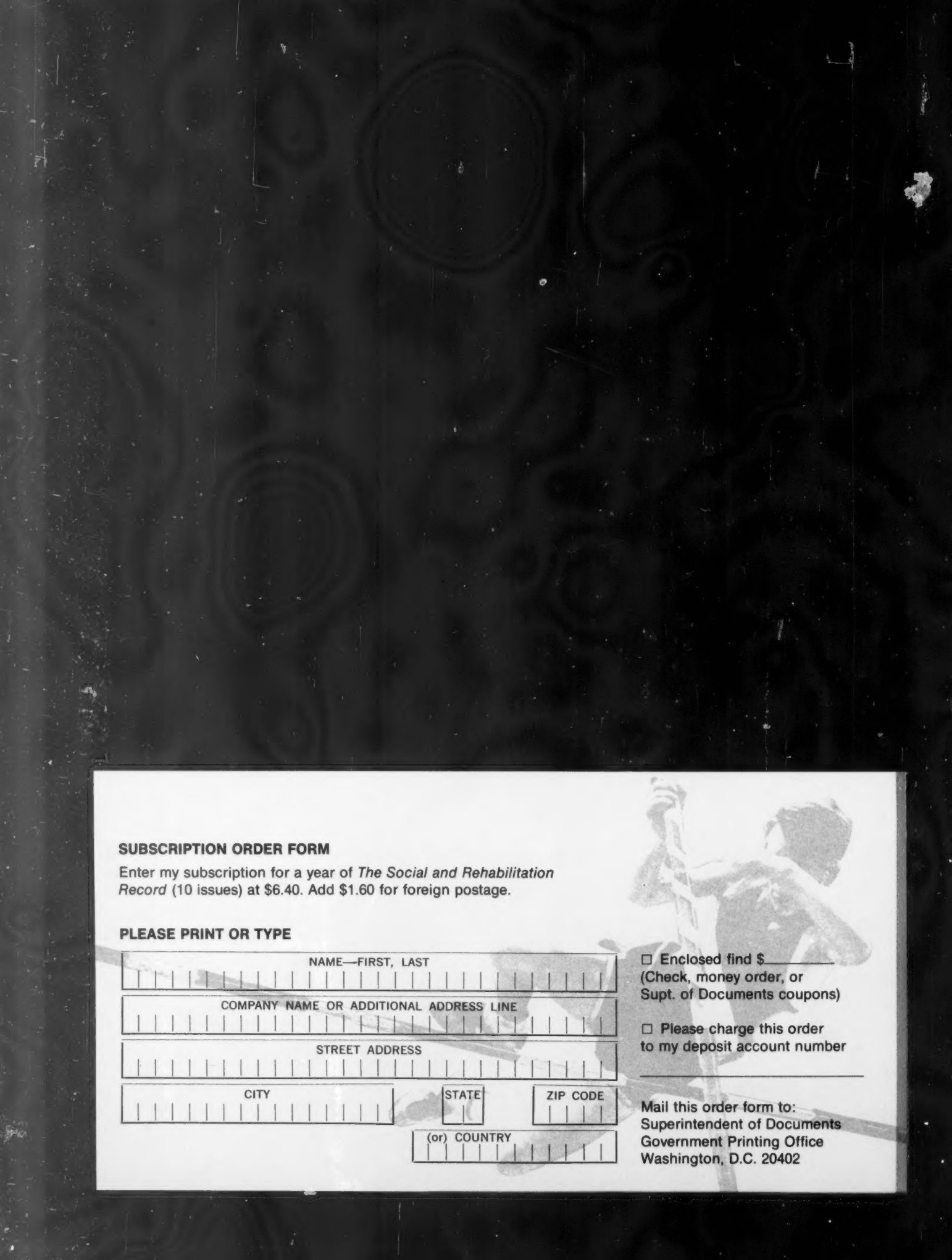
He will never find the answer if he can't see the problem.

If your child needs glasses, the Medicaid Program can provide them. Just as we provide immunizations against polio, whooping cough, and measles . . . treat anemia, TB, and sickle cell disease. To find out if your family is eligible, contact your local Social Service or Welfare Office today.

Medicaid. Worth looking into.

A new Record.

The Social and Rehabilitation Record keeps you ahead in the field.



SUBSCRIPTION ORDER FORM

Enter my subscription for a year of *The Social and Rehabilitation Record* (10 issues) at $6.40. Add $1.60 for foreign postage.

PLEASE PRINT OR TYPE

NAME—FIRST, LAST

COMPANY NAME OR ADDITIONAL ADDRESS LINE

STREET ADDRESS

CITY | STATE | ZIP CODE

(or) COUNTRY

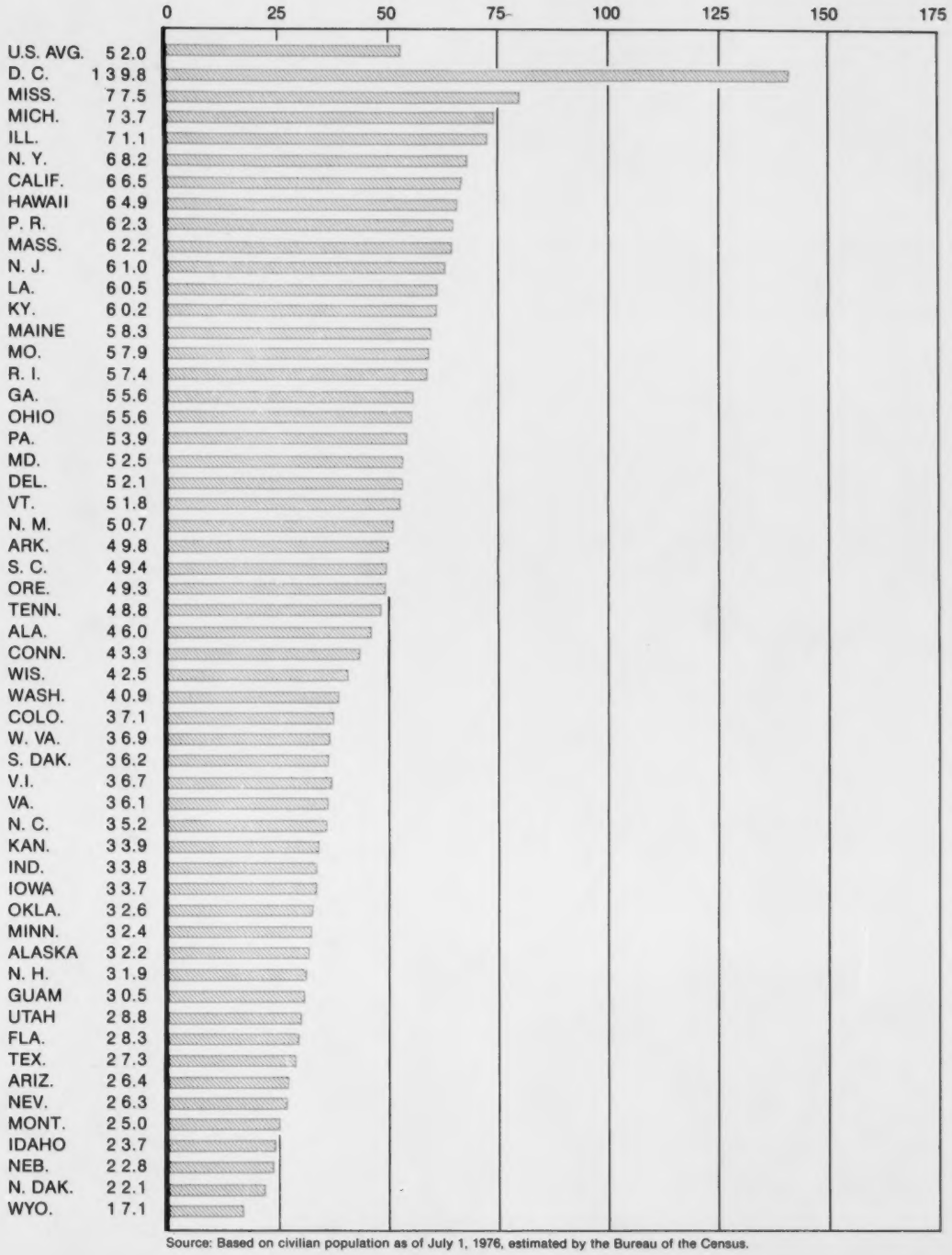
☐ Enclosed find $_____
(Check, money order, or Supt. of Documents coupons)

☐ Please charge this order to my deposit account number

_____

Mail this order form to:
Superintendent of Documents
Government Printing Office
Washington, D.C. 20402

Number of AFDC Recipients for June 1976 (per 1,000 persons)



Source: Based on civilian population as of July 1, 1976, estimated by the Bureau of the Census.

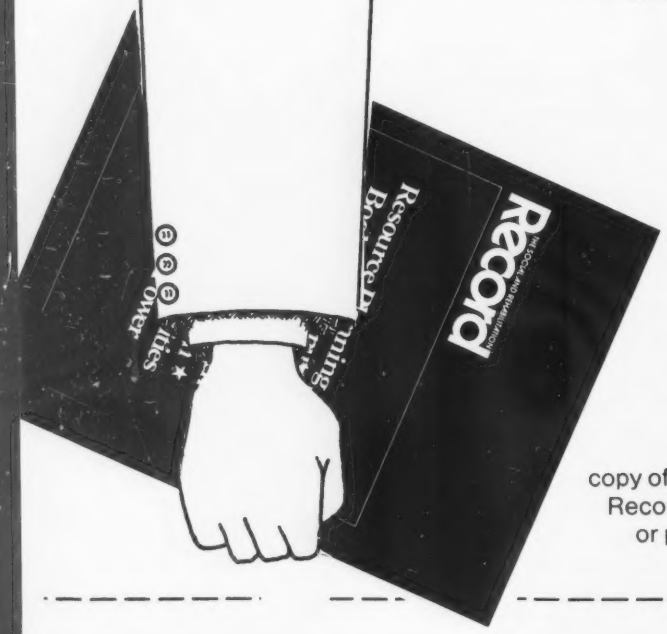
Social and Rehabilitation Service
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Washington, D.C. 20201

Official Business

Postage and Fees Paid
U.S. DEPARTMENT OF H.E.W.
HEW-392

FIRST CLASS

SRR SERIA300SDISSDUE003R 1
SERIALS DEPT XEROX UNIV
MICROFILMS
300 NORTH ZEEB RD
ANN ARBOR MI 48106



Keep Up With the Field

Make sure you obtain your copy of the Social and Rehabilitation Record. Fill out a subscription form or pass this along to a colleague.

Subscription form for The Social and Rehabilitation Record

Subscription Rate:
$6.40 a year
($8.00 foreign)
Single copy .85¢

NAME—FIRST, LAST

ORGANIZATION

ADDRESS

CITY | STATE | ZIP CODE | REG.

Send check, payable to SUPERINTENDENT OF DOCUMENTS to the U.S. Government Printing Office, Washington, D.C. 20402